

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01809 REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) William Eugene Alexander | | | | | | | | | | 2a. DATE OF DEATH MONTH Jan DAY 21 YEAR 1979 | | 2b. HOUR 4⁰⁰ P M | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH Aug. DAY 15 YEAR 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS 77 DAYS 77 HOURS 77 MIN. | | IF UNDER 24 HRS HOURS 77 MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Acct. | | 12b. KIND OF BUSINESS OR INDUSTRY Self Employed | | | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Hartford | | 13c. CITY OR TOWN Aberdeen | | 13d. STREET ADDRESS Apt B-25 309 S. Park ST. | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE Alexander LAST Alexander | | | | 15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Frederick LAST Frederick | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 315-16-9061 | | 17. INFORMANT ADDRESS Jennie L. Alexander, Aberdeen, Maryland. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive C.V.A. - Unconscious 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) A.S. C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 2 years | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Urinary Tract Infection | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1979 to Jan. 24, 1979 , that (I) (we) last saw the deceased alive on Jan 21 st, 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Edward C. Loo, MD | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/21/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARDS, Loo, MD | | | | 22e. ADDRESS Havre de Grace, Md 21078 | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan 24, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit, Cecil, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Lee G. Patterson ADDRESS Sm. Perryville, Md | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1979 | | | | 25b. REGISTRAR'S SIGNATURE Robert K. Bailey | | | | | |

20810-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01810

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|----------------------|--|--------------------|--|-------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | JAN. | | 7, 1979 | | 4 ⁰⁰ M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | 8 IF UNDER 24 HRS. | | | |
| MALE | | White | | JUNE 13, 1898 | | 80 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| ITALY | | U.S.A. | | | | HARFORD | | | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| HAURE de GRACE | | HARFORD Memorial Hospital | | SENNERY EXPERT | | RETIRED | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Md. | | HARFORD | | HAURE de GRACE | | YES | | 600 Lewis, S. STREET | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| JOSEPH | | JOSEPHINE | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | |
| YES. | | W.W. 11 | | M. MABEL V. ANDENORI - SAME | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 4140 | | Cerebral Recol failure | | | | 2 days | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | 6 days | | | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | ANTERIOSCLEROTIC HEART DISEASE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| MICRONODULAR CIRRHOSIS, MODERATE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a.1 certify that (I) (this hospital) attended the deceased from 1-1, 19 79, to 1-7, 19 79, that (I) (we) last saw the deceased alive on 1-7, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| | | RAMIRO R. LINDADO M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 1-7-79 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| RAMIRO R. LINDADO | | HARFORD MEMORIAL HOSP. HAURE DE GRACE | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| BURIAL | | JAN 10, 1979 | | ANGEL HILL CEM. | | HAURE DE GRACE HARFORD, MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| R. Madison Mitchell | | JAN 10 1979 | | [Signature] | | | | | | | | | |

BP

01810-05

BP _____
DHMH - 16 50M 7/77
(VRA 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01811 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charlie Baxter Bare</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>JANUARY 5, 1979</i> | | | | 2b. HOUR <i>5 AM</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 25, 1907</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Harford</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Painter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Martins</i> | | | |
| 13a. STATE <i>Md</i> | | 13b. COUNTY <i>Harford</i> | | 13c. CITY OR TOWN <i>Jarrettsville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>1911 Green Hill Road</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Jessie M. Bare</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rachel Taylor</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WW II</i> | | | | 16b. SOCIAL SECURITY NO. <i>241-22-2983</i> | | 17. INFORMANT <i>Homer D. Bare</i> | | ADDRESS <i>same as above</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1629 Bronchogenic carcinoma with</i> DUE TO, OR AS A CONSEQUENCE OF <i>carcinomatosis, left lung.</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-4</i> 19 <i>79</i> to <i>1-5</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>1-5</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Sang W. Kim</i> | | | | DEGREE <i>M.D.</i> | | | | 22c. DATE SIGNED <i>Jan. 6, 79</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SANG W. KIM</i> | | | | 22e. ADDRESS <i>801 S. Union Ave. Harford, Md. 21078</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>1/8/1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Mem. Gar.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bel Air, Harford, Md.</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>M. G. Kurtz III</i> | | | | ADDRESS <i>Jarrettsville, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 9 1979</i> | | 25b. REGISTRAR'S SIGNATURE <i>Patricia H. Bandy</i> | | | |

MEDICAL CERTIFICATION

11810-92

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 72-01812 MEDICAL EXAMINER REG. NO. | | | | | | | |
|---|--|--|---|--|---|--|---|--|-------|--|------|----------|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | MONTH | DAY | YEAR | 2b. HOUR |
| Henry Adam BARTKOWIAK | | | | | 1-20 | | | | 79 | | | 4:03 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| M | | W | | MONTH DAY YEAR 7 20 14 | | 64 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| USA | | USA | | | | HARFORD MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Harve de Grau | | HARFORD Memorial Hsp | | | | Nurseryman | | Nursery | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 430 Priestford Rd | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Henry Stanley Bartkowiak | | | | | Frances -- Budzynski | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| no | | | | | 222-30-6180 | | Mrs. Frances E. Kahl, Perry Hall, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) CORONARY HEART DISEASE | | | | | | | | | | | | |
| 4140 DUE TO, OR AS A CONSEQUENCE OF ASCVD | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | | |
| Louis E. Renjel MD | | | | | | Deputy Medical Examiner | | 1-21-79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | |
| Louis E. Renjel MD | | | | | | 464 Alliance St Harve de Grau | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | Jan. 24, 1979 | | Bel Air Mem Gardens | | Bel Air Harford Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| Howard K. McComas III, Abingdon, Md. | | | | | | | | JAN 25 1979 | | | | |

10-01815

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01813 REG. NO. | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Edith E. Bostick | | | | | | 1 | | 12 | | 79 | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 10 18 00 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cannery Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Jarrettsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3112 Rocks Chrome Hill Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Theodore Norris | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Jones | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown | | | | 16b. SOCIAL SECURITY NO. 220-14-2589 | | 17 INFORMANT ADDRESS 3112 Rocks-Chrome Hill Road Mary E. Cox, Jarrettsville, Md. 21084 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Car transportation accident</i> 4392 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebrovascular accident</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Degenerative arthritis</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE | | | | 22c. DATE SIGNED 1/13/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. YAMAKAWA M.D. | | | | 22e. ADDRESS 319 So. Union Ave. Havre de Grace Md. 21088 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 16, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Highland | | 23d. LOCATION CITY OR TOWN COUNTY STATE Street Harford Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John H. Harkins, Delta, Penna. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 18 1979 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

72-01813

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01814 REG. NO. | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) VORNA F. Budnick | | | 2a. DATE OF DEATH MONTH JANUARY DAY 23 YEAR 1979 | | | 2b. HOUR 2 MIN 30 | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 9 DAY 1 YEAR 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Harford | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teller | | | 12b. KIND OF BUSINESS OR INDUSTRY Banking | | |
| 13a. STATE MD. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Aberdeen | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 103 Edmund St | | | |
| 14. FATHER'S NAME FIRST FREDERICK MIDDLE H. LAST Budnick | | | | 15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE LAST Walters | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-18-0137 | | 17. INFORMANT ADDRESS Willard L. Budnick, 642 Sadler St., Aberdeen, Maryland 21001 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Multiplo Myeloma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days about 2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Peptic ulcer disease, Secondary Anemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1-17-79 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. 19 MONTH 1 DAY 17 YEAR 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-17-79 to 1-23-79 , that (I) (we) lost saw the deceased alive on 1-23-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edward C. Loo, M.D. | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/23/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Loo, M.D. | | | | 22e. ADDRESS Haure de Grace, Ind. 21078 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 26 Jan. 1979 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran | | 23d. LOCATION CITY OR TOWN Aberdeen, R.D. COUNTY Harford STATE Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1979 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 79-01815 | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Mary | | V. | | Chraxis | | | | Jan 26 1979 | | 7:27 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 2 HRS HOURS MIN. | |
| Female | | white | | 2 28 1894 | | 84 YRS. | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Poland | | USA | | | | Harford MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Havre de Grace | | Harford Memorial Hosp | | | | Retired | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md. | | Harford | | Havre de Grace | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 265 Wilson ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| | | 216-14-4787 | | Olivia Forney | | 829 Erie St. | | HUG MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> | | | | | | | | | | | |
| 5789 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute coronary insufficiency</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>After gastroenteric bleed</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 26, 1979, to Jan 26, 1979, that (I) (we) lost saw the deceased alive on Jan 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| | | | | | | 6/6/59 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| H. VANDERKAM M.D. | | 319 So. Union Ave. Hg Md 21078 | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| | | 2-31-79 | | MT. ERIN Cem | | Havre de Grace Harford MD | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| ARNOLD W. BEARD FUNER | | 117 Cecil Ave | | | | FEB 8 1979 | | | | | |

21810-02

NOTICE TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. **NOTICE TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-01816 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|--|--|--|--|--|--|---------------------------------------|--|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 20. DATE KNOWN OF DEATH | | | | | | | | | | 21. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. SEX | | | | | | | | | | 3. RACE | | | | | | | | | | 4. DATE OF BIRTH | | | | | | | | | | 5. AGE (IN YEARS) | | | | | | | | | | 6. IF UNDER 1 YR. | | | | | | | | | | 7. IF UNDER 24 HRS. | | | | | | | | | | 8. DATE PRONOUNCED DEAD | | | | | | | | | | 9. MONTH | | | | | | | | | | 10. DAY | | | | | | | | | | 11. YEAR | | | | | | | | | | 12. HOUR | | | | | | | | | |
| 13. BIRTH PLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 14. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 15. MARRIED | | | | | | | | | | 16. NEVER MARRIED | | | | | | | | | | 17. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | 18. MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. CITY OR TOWN OF DEATH | | | | | | | | | | 20. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | | | 21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 22. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 24. 13a. STATE | | | | | | | | | | 25. 13b. COUNTY | | | | | | | | | | 26. 13c. CITY OR TOWN | | | | | | | | | | 27. 13d. INSIDE CITY LIMITS? | | | | | | | | | | 28. 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29. FATHER'S NAME | | | | | | | | | | 30. MOTHER'S MAIDEN NAME | | | | | | | | | | 31. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 33. SOCIAL SECURITY NO. | | | | | | | | | | 34. INFORMANT | | | | | | | | | | 35. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 36. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | 37. PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | 38. IMMEDIATE CAUSE (a) | | | | | | | | | | 39. DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 40. (b) | | | | | | | | | | 41. DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 42. (c) | | | | | | | | | | 43. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 44. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | 45. CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 46. 19a. DATE OF OPERATION | | | | | | | | | | 47. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 48. 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 49. 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | | | | | | | 50. 21b. TIME OF INJURY | | | | | | | | | | 51. 21c. HOW INJURY OCCURRED | | | | | | | | | | 52. 21d. INJURY OCCURRED | | | | | | | | | | 53. 21e. PLACE OF INJURY | | | | | | | | | | 54. 21f. LOCATION | | | | | | | | | | 55. CITY OR TOWN | | | | | | | | | | 56. COUNTY | | | | | | | | | | 57. STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 58. 22a. I certify that I took charge of the remains described above, held an | | | | | | | | | | 59. Autopsy | | | | | | | | | | 60. Inspection | | | | | | | | | | 61. Inquiry | | | | | | | | | | 62. and in my opinion | | | | | | | | | | 63. death resulted from: | | | | | | | | | | 64. Natural causes | | | | | | | | | | 65. Accident | | | | | | | | | | 66. Suicide | | | | | | | | | | 67. Homicide | | | | | | | | | | 68. Undetermined manner | | | | | | | | | |
| 69. ACTUAL SIGNATURE | | | | | | | | | | 70. TITLE (SPECIFY) | | | | | | | | | | 71. M.D. | | | | | | | | | | 72. MEDICAL EXAMINER | | | | | | | | | | 73. DATE SIGNED | | | | | | | | | | 74. 1/25/79 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 75. EXAMINER'S NAME | | | | | | | | | | 76. ADDRESS | | | | | | | | | | 77. 2404 Pleasantville Rd. Fallston Md 21042 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 78. 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 79. 23b. DATE | | | | | | | | | | 80. 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 81. 23d. LOCATION | | | | | | | | | | 82. CITY OR TOWN | | | | | | | | | | 83. COUNTY | | | | | | | | | | 84. STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 85. 24. FUNERAL DIRECTOR | | | | | | | | | | 86. ADDRESS | | | | | | | | | | 87. 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 88. 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 89. JOHN H. HARKINS, DELTA, PA. | | | | | | | | | | 90. JAN 24 1979 | | | | | | | | | | 91. R. H. HARKINS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

18-01818

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-01817

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| FIRST MIDDLE LAST | | Jan 20 1979 | | 6 35 PM | |
| 3 SEX | | RACE | | 5. DATE OF BIRTH | |
| Female | | white | | MONTH DAY YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Maryland | | USA | | 82 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Harford | | Harford Memorial Hosp | | Harford MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | |
| Homemaker | | Home | | 225 Walnut Lane | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | Harford | | Aberdeen | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 16b. SOCIAL SECURITY NO. | |
| Winfield Scott Bayless | | Louise Cole | | 220-22-0275 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>2049</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | |
| Vernon L. Coale, 11 N. Reed St., Bel Air, Md. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 1 Year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 12</u> 19 <u>79</u> , to <u>Jan 20</u> 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>Jan 20</u> 19 <u>79</u> , and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not view the body after death). | | 22b. SIGNATURE <u>B. J. Plunkett Jr M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED <u>Jan 21, 1979</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. J. PLUNKETT M.D.</u> | | 22e. ADDRESS <u>Harford Memorial Hosp</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>23 Jan. 1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem. Gardens</u> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bel Air Harford Maryland</u> | | 24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 25 1979</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Patrick McCreedy</u> | | | | | |

MEDICAL CERTIFICATION

99

BP

70-01817

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-01818 | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT MADISON COPENHAVER, Jr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-10-79 | | 2b. HOUR 10:25 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Terminal Supr. | | 12b. KIND OF BUSINESS OR INDUSTRY Trucking | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppa | | 13e. STREET ADDRESS 205 Duryea Drive | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Madison Copenhaver | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Matilda Kelly | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 227-03-3115 | | 17. INFORMANT ADDRESS Mrs. Mildred Copenhaver, Joppa, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATE CANCER 185- DUE TO, OR AS A CONSEQUENCE OF (b) BONE METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE ANEMIA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Howard K. McComas III DEGREE | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ZEPHO M.D. | | | | | | 22e. ADDRESS 742 Joppa Farm Rd, Joppa, Md 21078 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Jan. 13, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process Crematory | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md. | | 23e. DATE REC'D. BY REGISTRAR JAN 12 1979 | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. | | | | | | 23e. DATE REC'D. BY REGISTRAR JAN 12 1979 | | 23f. REGISTRAR'S SIGNATURE Howard K. McComas III | | | |

81810-25

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01819

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|---|--|---|--|---|----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Ida Mary Cotter | | | 2a. DATE OF DEATH 1-9 79 | | | 2b. HOUR 1:PM | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH 2 DAY 11 YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A (Md) | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford | | | | |
| 10. CITY OR TOWN OF DEATH Havre De Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY Home maker | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE Md | 13b. COUNTY Harford | 13c. CITY OR TOWN Joppa | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 422 Larkspur Dr. | | | |
| 14. FATHER'S NAME FIRST Peter MIDDLE Delss LAST Delss | | | 15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE Bessie LAST Bessie | | | 16. ADDRESS r. Joppa | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-18-7126 | | 17. INFORMANT Mrs. John Crossin, 422 Larkspur Dr. Joppa | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car door accident 4392 DUE TO, OR AS A CONSEQUENCE OF (b) Compensated heart failure. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus Blood loss event | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/9/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMASKAWA M.D. | | 22e. ADDRESS 319 So Union Ave Hg Md 21001. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/11/79 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION CITY OR TOWN Dundalk COUNTY Baltimore STATE Maryland | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc., Baltimore, Maryland ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1979 | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

28-01812



Special Agent in Charge, Bureau of Investigation, Department of Justice
Washington, D.C. 20535

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01820

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>James M. Counts</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 9 79</i> | | | 2b. HOUR <i>1:30 P.M.</i> | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>1 17 95</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford, City</i> MD | | |
| 10. CITY OR TOWN OF DEATH <i>Bel Air</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bel Air Nurs. Conv. Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Security guard</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Martin Co</i> | | |
| 13a. STATE <i>Md.</i> | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Crabshaw</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Bruce Counts</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nannie Edwards</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>224 18 4518</i> | | 17. INFORMANT <i>George A. Counts</i> ADDRESS <i>532-1 Range Rd. White Marsh Md.</i> | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Myocardial Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis severe</i> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>1-6-79</i> to <i>Jan. 29</i> , 19 <i>61</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>William A. Tyson</i> | | | | DEGREE | | 22c. DATE SIGNED <i>1-9-79</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William A. Tyson</i> | | | | 22e. ADDRESS <i>Kingsville Md. 21087</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1-11-1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Belair Memorial Gar.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Belair Harford Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1979</i> | | 25b. REGISTRAR'S SIGNATURE <i>Barry McCreedy</i> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

12-01850



NAME: James Harrison Crandall

DATE OF DEATH: January 12, 1979

PLACE OF DEATH: Harford County

SEE: #79-04496
February, 1979
Harford County



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-01821 | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) LUCILE S. Crawford | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 79 | | 2b. HOUR 6:15 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02-20-93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85yrs. | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 74 HRS. HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Havre-De-Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Havre-De-Grace | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 16 MARLYN RD. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Stuart | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorena Moore | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-48-5559 | | 17. INFORMANT Mr. Frank C. Hart ADDRESS 16 MARLYN RD. CHESTNUT HILL NEWARK, DEL. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 5990 IMMEDIATE CAUSE (a) Urinary tract infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Due to, or as a consequence of (c) Due to, or as a consequence of PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis; chronic brain syndrome | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hr. | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-7 79 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1-5 - 1979 , to 1-7 79 , that (I) (we) lost above (underline) did not view the body after death. and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE Peter P. Roeman, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-8-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 8 Lawst. Aberdeen, Md. 21001 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 11, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun Cecil Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME R. Madison Mitchell ADDRESS HAVRE DE GRACE, MD. | | | | | | 25. DATE REC'D. BY REGISTRAR JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

15810-02

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL. 60637

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01822 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST GRAVE LESLIE CRONIN | | | | 2b. HOUR 4 P. M. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY LINCOLN NEBRASKA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | |
| 10. CITY OR TOWN OF DEATH Bel Air | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 583 Cressy Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaker | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | | 13c. CITY OR TOWN Bel Air | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE FARNHAM BAKER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINERVA FARNHAM | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579-16-4015-B | | 17. INFORMANT (Son) 838-3969 Mr. Cornelius F. Cronin | | ADDRESS 608 Ridgely Road Bel Air, Maryland 21014 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4280 } DUE TO, OR AS A CONSEQUENCE OF (b) SENILITY (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Philip W. Heuman M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED Jan. 29, 1977 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip W. Heuman, M.D. | | | | 22e. ADDRESS 307 Hickory Ave., Bel Air, Maryland 21014 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Feb. 1, 1977 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford County, Maryland 21014 | |
| 24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral | | | | 25a. DATE REG'D. BY REG'D. BY W. Brandy & Williams Bel Air, Maryland 21014 | | 25b. REGISTRAR'S SIGNATURE | |

55810-25

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-01823 | |
|---|---------------------|--|--|--|--|--|--|--|------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lawrence A. Eiring | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 123 19 79 | |
| 3. SEX M | 4. RACE Cauc | 5. DATE OF BIRTH (MONTH DAY YEAR) 11 6 16 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD 19 | 7d. HOUR 158 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed | | 12b. KIND OF BUSINESS OR INDUSTRY Hardware | | | |
| 13a. STATE MD | | 13b. COUNTY Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Benton Heights Avenue | | | | | |
| 14. FATHER'S NAME FIRST George MIDDLE J. LAST Eiring | | | | 15. MOTHER'S MAIDEN NAME FIRST Evelyn MIDDLE Smith LAST Smith | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 214-01-3182 | | | | 17. INFORMANT Henry Eiring (brother) | | | | ADDRESS 12913 Fork Rd. Baldwin Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 Cardiac Arrest IMMEDIATE CAUSE (a) AS. W.O. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) AS. W.O. DUE TO, OR AS A CONSEQUENCE OF (c) AS. W.O. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE W Amos | | | | TITLE (SPECIFY) Asst Deputy M.D. | | | | MEDICAL EXAMINER DATE SIGNED 1/23/79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amos | | | | ADDRESS 2404 Pleasantville Rd Fallston Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/26/79 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN Balto. COUNTY Md. | | | | | |
| 24. FUNERAL HOME NAME Schrimunek Funeral Home, Inc. ADDRESS 9705 Belair Rd. Balto. Md. 21236 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 25 1979 | | 25b. REGISTRAR'S SIGNATURE Robert A. Cready | | | | | |

58-01853

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01824

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) DORIS S. Adeley | | | 2a. DATE OF DEATH Month 1 Day 13 Year 79 | | | 2b. HOUR 7:25 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 12-6-1887 | | 6. AGE (in years last birthday) 91 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Harford County Md. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brevin Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Havre de Grace | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 3801 Rider Lane | | 14. FATHER'S NAME First Fred Middle - Last SULLIVAN | | 15. MOTHER'S MAIDEN NAME First LENA Middle - Last Bertholdt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - | | 16b. SOCIAL SECURITY NO. 214-26-4675 | | 17. INFORMANT Mrs. Marian D. Rider, Havre de Grace, Md. 21078 | | Address 3801 Rider Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12, 1979 , to 1-13 , 19 79 , that (I) (we) lost saw the deceased alive on Jan 12, 1979 , and that in (my) (our) opinion death occurred on the date and hour on from the cause stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE SANG I. D. KIM, M.D. | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 13, 79 | |
| 22d. PHYSICIAN'S NAME (Type) SANG I. D. KIM | | 22e. ADDRESS 801 S. Union Ave. Havre de Grace, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE JAN. 16, '79 | | 23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM. | | 23d. LOCATION (City or Town) (County) (State) HAVREDEGRACE HARFORD MD. | |
| 24. FUNERAL DIRECTOR R. Modwen Mitchell, Havre de Grace, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE Jeffrey M. Cready | |

MEDICAL CERTIFICATION

45810-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-01825

| | | | | | |
|--|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| FIRST MIDDLE LAST | | January 1, 1979 | | 11 P. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 75 YRS. | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | Hartford MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Havre de Grace | Hartford Memorial Hosp | | Aide | | V.A. Hospital |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Md | | Hartford | Havre de Grace | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 505 Congress St. Apt 301 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Walter P Boyd | | Carrie Wilson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 172-24-7279 | | Grace B. Burton, Perryville, Maryland. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) (b) (c) | | | | | |
| 4410 Rupture dissecting aortic aneurysm - 1 day | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive - atherosclerotic heart disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Female | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-28-1978 to 1-1-1979, that (I) (we) last saw the deceased alive on 1-1-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Irvin H. Wachsmann | | | | 1/7/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| IRVIN H. WACHSMAN | | 407 Sunning Ave, Havre de Grace, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Jan. 4, 1979 | | Asbury Cemetery | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Lee A. Attenson & Son | | Perryville, Maryland | | JAN 11 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

70-01852

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01826

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|---|----------------------|---|--|---|---|--|--|---|---|--|--|
| 1. DECEASED-NAME (Type or Print) <u>Stella</u> <u>ELIZABETH</u> <u>Foreman</u> | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>1</u> Day <u>8</u> Year <u>1979</u> | | | 2b. HOUR <u>11:58</u> M | | |
| 3. SEX <u>F</u> | 4. RACE <u>White</u> | 5. DATE OF BIRTH <u>Mar. 27, 1884</u> | 6. AGE (in years last birthday) <u>94</u> YRS. | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | IF UNDER 24 HRS. HOURS _____ MIN _____ | 2c. DATE PRONOUNCED DEAD Month _____ Day _____ Year <u>19</u> | | | 2d. HOUR _____ M | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Penna.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Harford Co.</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Fallston</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Fallston General Hospital</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u> | | 13b. COUNTY <u>Harford</u> | | 13c. CITY OR TOWN <u>Edgewood</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>1936 Sidhee Drive</u> | | | |
| 14. FATHER'S NAME First <u>George</u> Middle <u>--</u> Last <u>Shearer</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u>--</u> Last <u>Defibaugh</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16b. SOCIAL SECURITY NO. <u>210-12-0080A</u> | | 17. INFORMANT ADDRESS <u>Mrs. Geo. W. Foreman, Edgewood, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerotic Heart Disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Willard R. Amoss</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>1/8/79</u> | | | |
| EXAMINER'S NAME (Type) <u>Willard R. Amoss</u> | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>Jan. 8, 1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Garman F.H.</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Liverpool, Perry Co. Pa.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Howard K. McComas III, Abingdon, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>JAN 10 1979</u> | | 25b. REGISTRAR'S SIGNATURE <u>Walter J. McCreedy</u> | | | | | |

18-01856

MINISTÈRE DE LA SANTÉ

FOR DATE
HEALTH UNIT

2000-01-05

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 79-01827 | | | |
|---|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Theresa L. Gibson | | | | January 27 1979 2:12 AM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 / 18 / 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. 13b. COUNTY Harford 13c. CITY OR TOWN Bel Air | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 128 Alice Ann St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Thomas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - L. Barrett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO 213-16-9313 | | 17. INFORMANT ADDRESS Celia A. Jackson Monkton, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pericardial Effusion | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week |
| 4239 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Brown - eff. - initial sufficiency | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-21-79 to 1-27-79, that (I) (we) last saw the deceased alive on 1-27-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. de la Cruz MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. de la Cruz SANTOS | | | | 22e. ADDRESS 2835 Churchville Churchville, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/1/79 | | 23c. NAME OF CEMETERY OR CREMATORY Clarks Chapel | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hickory Harford MD | |
| 24. FUNERAL DIRECTOR NAME Title's Funeral Home | | | | ADDRESS Bel Air, MD | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 29 1979 [Signature] | |

BP

79-01827

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-01828 | |
|---|--|--|--|---|--|---|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Michael Bernard Gillease | | | | | | Jan 4 1979 | | 7:15 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | Oct. 28, 1888 | | 90 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Havre de Grace | | Harford Memorial Hospital | | | | Dep. Marshall | | | Fed. Govt. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 4015 Philadelphia Rd. | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Bernard -- Gillease | | | | | | Mary -- Bayless | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | | | | | 24-30-8821 | | Mrs. Mary Gillease, Abingdon, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | year | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease | | | | | | | | | | year | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Renal failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 30, 1978, to Jan 4, 1979, that (I) (we) last saw the deceased alive on Jan 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| Rene Delosantos | | | | | | M.D. | | | 1/5/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| Rene Delosantos MD. | | | | | | Churchville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | | | |
| Burial | | Jan 8, 1979 | | St. Francis Cem. | | Abingdon | | Harford Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Howard K. McComas III, Abingdon, Md. | | | | | | JAN 8 1979 | | | [Signature] | | |

85810-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 19-01829

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) DOWNIE NMN GILLIAM | | | 2a. DATE OF DEATH MONTH DAY YEAR 1- 15- 79 | | | 2b. HOUR 8:50 AM | |
| 3 SEX M | | 4 RACE W | | 5 DATE OF BIRTH MONTH DAY YEAR 4 10 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 10 CITY OR TOWN OF DEATH HAUCE DE GRACE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner - Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Coal | |
| 13a. STATE MD | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN CHAURCHVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Drew S. Gilliam | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Addington | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 405-05-7150 | | 17 INFORMANT ADDRESS Churchville, Md. 21028 M. Joyce Hall, 3107 Rolling Green Drive. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (1b) and (c). PART I. DEATH WAS CAUSED BY: 797- old age IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-1 , 19 78 , to 1- 15 , 19 79 , that (I) (we) last saw the deceased alive on 1- 15 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE John A. Yun | | DEGREE | | 22c. DATE SIGNED 1/15/79 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Yun | |
| 22e. ADDRESS Hauce de Grace, Md | | 23a. NAME OF CEMETERY OR CREMATORY Jarnigan Cemetery | | | | | |
| 23b. DATE 16 Jan. 1979 | | 23c. LOCATION CITY OR TOWN COUNTY STATE Morristown Hamblen Tenn. | | 23d. DATE REC'D. BY REGISTRAR 23e. REGISTRAR'S SIGNATURE JAN 19 1979 | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001 | | | | | | | |

MEDICAL CERTIFICATION

16-01852

Handwritten notes and signatures, including "L. J. [illegible]" and "J. [illegible]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01830 REG. NO. | |
|---|--|--|--|---|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Jean Lorraine Grace</u> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>January 18 1979</u> | | | 2b. HOUR <u>11:30</u> AM | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>11 29 1925</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>53</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>California</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Harford</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Harford Memorial Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Inspector</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Belko Corp.</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md</u> | | | | | | 13b. COUNTY <u>Harford</u> | | 13c. CITY OR TOWN <u>Aberdeen</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Unknown</u> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Unknown</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>546-34-0053</u> | | 17. INFORMANT ADDRESS <u>Leonard D. Grace, 816 Stepney Road, Aberdeen, Md 21001</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF: b) <u>With Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF: c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>John D. Yun</u> | | | | | | DEGREE | | 22c. DATE SIGNED <u>1/18/79</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN D. YUN</u> | | | | | | 22e. ADDRESS <u>Harford</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>23 Jan. 1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Harford Mem. Gardens</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Aberdeen, R.D., Harford Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 23 1979</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

16-01830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 79-01831 | |
|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Edgar EUGENE GRAFTON | | 01 07 79 | | 7:23 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| MALE | White | Sept. 29, 1904 | 74 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| First Hill Maryland | U.S.A. | | Hartford County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Fallston | FALLSTON GENERAL HOSPITAL | | Farm Hand | | Agriculture |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | Hartford Co. | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | |
| Edgar Elwood Grafton | | Bertha May Ward | | 1300 Conowingo Road | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (NAME) ADDRESS | | |
| NO | | 215-32-1626 | Mrs. Mary V. Riley 3615 Hess Road Monkton, Maryland 21111 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| Obstructive Lung Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | P.M. 19 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/78, 19, to 1/7/79, 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| Joseph Reinhardt M.D. | | | | 1-7-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Joseph A. Reinhardt | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | JAN. 9, 1979 | DEER CREEK Meth. Ch. Cem. | | Forest Hill, Hartford Co., Maryland 21050 |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Joseph William Foster | | JAN 10 1979 | | [Signature] | |

BP

10-01831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #15 per phone call w/Fun.

1- STATE REGISTRAR
Home 1/31/79 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01832
REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Clara Rue Graham | | | 2a. DATE OF DEATH MONTH DAY YEAR January 29 1979 | | | 2b. HOUR 12 58 A M | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY -- | |
| 13a. STATE Md | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Bel Air | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Edward Hill Dorsey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth -- Rue Dunn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 216-46-0246 | |
| 17 INFORMANT ADDRESS Col. William W. Graham III, Bel Air, Md | | 18 CAUSE OF DEATH Enter only one cause per line factors (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5789 IMMEDIATE CAUSE (a) Cold age (b) G. I. hemorrhage (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-18 1979, to 1-29 1979, that (I) (we) lost saw the deceased alive on 1-29 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John D. Yun | | DEGREE | | 22c. DATE SIGNED 1/26/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun | | 22e. ADDRESS Havre de Grace, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 29, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Md. | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, | | ADDRESS Abingdon, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE John D. Yun | |

70-01835

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-01833
REG. NO.

| | | | | | |
|--|---|--|--|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| BENTON HOPE GROSS, Sr. | | January 31, 1979 | | 9:30 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| MALE | White | Oct. 26, 1891 | 87 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bel Air | 9 Stoneleigh Place | BANKER | FINANCE | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Harford Co. | Bel Air | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 9 Stoneleigh Place | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| William Brierly Gross | | | Catherine Hope | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (NAME) ADDRESS | | |
| NO | | 217-16-3456-A | Mr. BENTON H. GROSS, Jr. 582 Ridgewood Road Bel Air, Maryland 21014 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>CARDIO-RESP. FAILURE</u> | | | | | 4 DAYS |
| 5909 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADVANCED ARTERIO SCLEROTIC CARDIO-VASC DIS.</u> | | | | | 2 WEEKS |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADVANCED AGE - CHRONIC KIDNEY INFECTION</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>50</u> to <u>31 JAN</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>30 JAN</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| <u>H. Proctor Sidwell M.D.</u> | | | | 31 JAN 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| H. Proctor Sidwell, M.D. | | | | 401 Franklin St., Bel Air, Md. 21014 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | FEB. 2, 1979 | Bel Air Memorial Gardens | Bel Air, Harford Co., Maryland 21014 | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Joseph William Foster Specialist, Inc. | | FEB 1 1979 | | Ruthy McCreedy | |

1. The attending physician must be notified of the death of the decedent within 24 hours after death. Pages 4 and 5 must be filed with the funeral director's permit. Pages 1 and 2 should be filed within 72 hours after death.

2. The attending physician must be notified of the death of the decedent within 24 hours after death. Pages 4 and 5 must be filed with the funeral director's permit. Pages 1 and 2 should be filed within 72 hours after death.

BP

10-01833



DHMH - 17
(VR A15 ME (5))
30M 7/73

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01834

REG. NO.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 79-01834 REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Herbert Godfrey Gwinner Jr. | | | | | | | | | | | |
| 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 1-13-79 | | | | | | | | | | | |
| 2b. HOUR M 3:26 PM | | | | | | | | | | | |
| 3. SEX M 4. RACE Cauc 5. DATE OF BIRTH MONTH DAY YEAR 8-20-30 6. AGE (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 48 YRS | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer 12b. KIND OF BUSINESS OR INDUSTRY US-govt. | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Harford 13c. CITY OR TOWN Forest Hill 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1605 Barbours Court | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herbert Gottfried Gwinner, Sr. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Jones | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 190-26-2701 17. INFORMANT ADDRESS Mrs. Mildred Gwinner, Forest Hill, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Willard P. Amoss TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1/14/79 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss ADDRESS 2404 Pleasantville Rd, Fallston, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Jan. 17, 1979 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 25a. DATE REC'D. BY REGISTRAR JAN 16 1979 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |

12-01834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01835 REG. NO. | | | | (1540A.M.) | | | |
|---|--|---|--|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROSE MARGARET HACKETT | | | | | | | | 2a. DATE OF DEATH MONTH 11 DAY 15 YEAR 79 | | | | 2b. HOUR 40 AM | | | |
| 3. SEX FEMALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 7 DAY 23 YEAR 1988 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH BEL AIR, MARYLAND | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL AIR CONV. + Nsg Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIKE) HOUSE COMPANION | | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN BEL AIR | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 447 MOORES Mill Rd. | | | | | |
| 14. FATHER'S NAME FIRST LOUIS MIDDLE ASTERITA LAST BRENNON | | | | 15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE BRENNON LAST BRENNON | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 089-26-8752 | | | | 17. INFORMANT (Print Name) Mrs Anne H. TEVLEN ADDRESS 447 MOORES Mill Road Bel Air, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) arteriosclerotic heart disease | | | | | | | | | | | | | | | |
| (c) arteriosclerosis, generalized | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1: (a) cerebrovascular insufficiency | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION - | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) - | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) - | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 77 , to 11/15 , 19 79 , that (I) (we) lost saw the deceased alive on 11/9 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Ben Oteyza DEGREE MD | | | | | | | | 22c. DATE SIGNED 11/15/79 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEN OTEYZA | | | | | | | | 22e. ADDRESS 715 SHAMROCK Rd. BEL AIR Md. 21014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE JAN. 18, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY St Ignatius Cath. Ch. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co., Md. 21050 | | | | | |
| 24. FUNERAL DIRECTOR Joseph William Foster | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1979 | | | | 25b. REGISTRAR'S SIGNATURE Dickey McCreedy | | | | | | | |

10-01832

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01836 REG. NO. | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 1-22-79 | | | | 1:55 AM | | | |
| 3 SEX | | | | 4 RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| Male | | | | White | | | | Aug. 7, 1929 | | | | 49 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | HARFORD COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| FALLSTON | | | | FALLSTON GENERAL Hospital | | | | Salesman | | | | Vehicles | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | | | Harford | | | | White Hall | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | 13e. STREET ADDRESS | | | | | | | |
| James Lyttleton | | | | Doras Elizabeth | | | | 4467 Norrisville Road | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17 INFORMANT | | | | ADDRESS | | | |
| Yes | | | | 1951-1954 | | | | 212-30-0934 | | | | Betty J. Hawkins same as above | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4149 | | | | | | | | | | | | 3 hr. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe C.A.D.</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | STREET | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-2-</u> 19 <u>79</u> , to <u>1-10-</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1-10-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | |
| <u>Man</u> | | | | MD | | | | 1/22/79 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | |
| V. S. Nann MD | | | | 200 Meltzer Ave - Fallston MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Burial | | | | 1/24/1979 | | | | Emmanuel Cemetery | | | | Monkton, Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NAME | | | | ADDRESS | | | | 21084 | | | | | | | |
| M. G. Kurtz III | | | | Jarrettsville, Md. | | | | JAN 24 1979 | | | | <u>Robert McQuinn</u> | | | |

18-01838

17

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11

18-01838

18-01838

18-01838

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

| FOR 1- STATE REGISTRAR | | | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 79-01837 | | | | | | | | | | | |
|--|--|---------------------|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>MARY BETTY Herring</i> | | | | | | 2a. DATE KNOWN OF DEATH MONTH <i>1</i> DAY <i>6</i> YEAR <i>1979</i> | | | | | | 2b. HOUR <i>9 PM</i> | | | | | | | | | | | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH <i>8</i> DAY <i>15</i> YEAR <i>1988</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>90</i> | | IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | | 2c. DATE PRONOUNCED DEAD MONTH <i>1</i> DAY <i>6</i> YEAR <i>1979</i> | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>HAVREDE GRACE</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD Memorial Home</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSE WIFE</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>SAME</i> | | | | | | | | | | | |
| 13a. STATE <i>Md.</i> | | | | 13b. COUNTY <i>HARFORD</i> | | 13c. CITY OR TOWN <i>BEL AIR</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>1361 Belcamp Rd - Bel Air</i> | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST <i>James</i> MIDDLE <i>W.</i> LAST <i>Patterson</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Cornie</i> MIDDLE <i>Bell</i> LAST <i>Patterson</i> | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>228-22-1250</i> | | 17. INFORMANT NAME <i>WILLIE GIBSON</i> ADDRESS <i>1361 BELCAMP ROAD, BEL AIR</i> | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY Heart Disease.</i> <i>4/40</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>ASLUD.</i> (c) <i>Compression</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Fractured L4-L5.</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Luis E. Renjel</i> | | | | TITLE (SPECIFY) <i>Deputy</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>1-7-79</i> | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Luis E. RENJEL</i> | | | | ADDRESS <i>464 Alliance St. Havre de Grace, Md.</i> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | | | 23b. DATE <i>1/11/1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>PORT REPUBLIC CEMETERY</i> | | | | 23d. LOCATION CITY OR TOWN <i>PORT REPUBLIC</i> COUNTY <i>ROCKHILL</i> STATE <i>Pa.</i> | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Pennington Law</i> ADDRESS <i>Havre de Grace, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1979</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i> | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

72-01837

10

INVESTIGATION OF THE
ACTS OF VIOLENCE
AND THE DESTRUCTION OF
PROPERTY
IN THE DISTRICT OF COLUMBIA
AND THE ADJACENT AREAS
DURING THE PERIOD
FROM JANUARY 1, 1968
TO JANUARY 1, 1969
BY
JAMES E. HARRIS
AND
JOHN F. HARRIS
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01838 REG. NO. | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR ³³ PM | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JEROME Clayton HOHREIN | | | | JAN. 6, 79 | | | | 10 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Anne Arundel Co. Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Hanford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY Automotive | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 3024 Laurel Bush Road - P.O. Box 51 | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford Co. | | 13c. CITY OR TOWN Abingdon | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Hohrein | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Margaret Anne Spath | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-09-2320 | | 17. INFORMANT (NAME, RELATIONSHIP, ADDRESS) Miss Margaret Anne Hohrein 3024 Laurel Bush Rd. - P.O. Box 51 Abingdon, Maryland 21009 | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest 303- DUE TO, OR AS CONSEQUENCE OF (b) Severe Metabolic Acidosis - Probably due to Cardiogenic Shock DUE TO, OR AS CONSEQUENCE OF (c) Acute and Chronic Alcoholism Approximate interval between onset and death: 30 min at least 5-6 hrs Several days | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes, Hypertension | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from JAN. 6th 1979 to JAN. 6th 1979 , that (2) we last saw the deceased alive on JAN. 6, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Albert S.C. Sun, M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Jan. 6, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. Sun, M.D. | | | | 22e. ADDRESS Fallston Hospital, 21047 MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE JAN. 9, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Episc. Ch. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon, Harford Co, Maryland 21009 | | | | | |
| 24. FUNERAL DIRECTOR Joseph William Foster | | | | ADDRESS W. Broadway Williams St. Bldg. A, Maryland 21014 | | | | 25a. DATE RECEIVED BY REGISTRAR JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01839 REG. NO. | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ELEANOR LAST Keen | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/25/79 | | | | 2b. HOUR 5:15 PM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2/5/96 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Harford | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY SAME | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Harford | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 415 S. Market St. | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Jesse MIDDLE (Gunner) LAST Paplan | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE (Winn) LAST McElathran | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. 218-05-0811 | | 17. INFORMANT Edward Keen 222 S. Parke St. Aberdeen MD | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>0381</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Systemic staph. infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1957 to 1979, that (I) (we) lost saw the deceased alive on 1/23/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 27a. SIGNATURE <u>[Signature]</u> | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1.25.1979 | |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/29/1979 | | 23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Harford MD. | | | |
| 24. FUNERAL DIRECTOR NAME <u>Cornelius J. Hamill, Inc.</u> ADDRESS _____ | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |
| JAN 30 1979 | | | | | | | | | | | |

BP

5a-01832

SECRET

NAME: Sonia A. Knutson

DATE OF DEATH: January 11, 1979

PLACE OF DEATH: Harford County

SEE: #79-04513
February, 1979
Harford County

WHITFIELD

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-01840 REG. NO. | | | | | |
|--|--|---------------------|--|---|--|---|--|---|--|---|--|--|--|--------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) NELSON Hubert Landis | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH 11 DAY 19 YEAR 79 | | 2b. HOUR 242 M | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH 5 DAY 8 YEAR 07 | | 6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD MONTH 1 DAY 1 YEAR 79 | | 2d. HOUR 242 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Pising Sun | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rd 2 Pising Sun Md | | | | | |
| 14. FATHER'S NAME FIRST Hess MIDDLE - LAST Landis | | | | | | 15. MOTHER'S MAIDEN NAME FIRST UNK. MIDDLE UNK. LAST UNK. | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 214-12-0663 | | 17. INFORMANT Hospital Chart Rec. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disor 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Lun E. Renjel | | | | | | TITLE (SPECIFY) Deputy M.D. | | | | DATE SIGNED 1-1-79 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) LUN E. RENJEL | | | | | | ADDRESS 464 Alliance Harv de Grace | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC.) Burial | | | | 23b. DATE Jan 4-79 | | 23c. NAME OF CEMETERY OR CREMATORY West Nottingham | | | | 23d. LOCATION CITY OR TOWN Colora COUNTY Rec. Co. STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME W. E. Mullen | | | | ADDRESS Pising Sun, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1979 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

04810-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01841

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|--|--|--------------------------------|--|--------------|--|--|--|------------|--|---------------|--|
| FOR 1- STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-01841 REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Wilson | | MIDDLE Leon | | LAST LOWERY, SR | | 7a. DATE KNOWN OF DEATH ESTI- MATED | | | | MONTH 15 | | DAY 19 | | YEAR 1979 | | 7b. HOUR 8:43 M | | | | | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 3 | | DAY 17 | | YEAR 08 | | 6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | MONTH 19 | | DAY 19 | | YEAR 19 | | 7d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor (ret) | | 12b. KIND OF BUSINESS OR INDUSTRY Joppa Towne Plaza | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE md | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppa | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Box 423 Demytown Rd. | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST ALBERT | | MIDDLE | | LAST LOWERY | | 15. MOTHER'S MAIDEN NAME FIRST LOTTIE | | MIDDLE | | LAST PEAKER | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE | | 17. INFORMANT (Daughter) Mrs Charlotte Couplin | | ADDRESS 2039 Battle St Edgewood Md | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Willard R Amoss | | TITLE (SPECIFY) M.D. Deputy | | MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 11/16/79 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Willard R Amoss | | ADDRESS 2404 Pleasantville Rd, Fallston, Md | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-20-1978 | | 23c. NAME OF CEMETERY OR CREMATORY TABERNACLE CHURCH | | 23d. LOCATION CITY OR TOWN Benson | | COUNTY Harford | | STATE md | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME E BARNES FLEMING | | ADDRESS Funeral Service Benson Md | | 25a. DATE RECD. BY REGISTRAR JAN 17 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

14810-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-01842 REG NO | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|---|--|-------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Garfield</u> MIDDLE <u>Franklin</u> LAST <u>Lyon</u> | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <u>1</u> DAY <u>6</u> YEAR <u>1979</u> | | 2b. HOUR <u>2:30</u> | | 2c. DATE PRONOUNCED DEAD MONTH <u>19</u> DAY <u>6</u> YEAR <u>1979</u> | | 2d. HOUR <u>M</u> | | | |
| 3. SEX <u>M</u> | | 4. RACE <u>Cauc.</u> | | 5. DATE OF BIRTH MONTH <u>11</u> DAY <u>10</u> YEAR <u>1896</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS. | | IF UNDER 1 YR. MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u> | | IF UNDER 24 HRS. MONTH <u></u> DAY <u></u> HOUR <u></u> MIN. <u></u> | | 7c. DATE PRONOUNCED DEAD MONTH <u>19</u> DAY <u>6</u> YEAR <u>1979</u> | | 7d. HOUR <u>M</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>North Carolina</u> | | | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>Fallston</u> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): | | | | | | | | | | | | | | | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>Harford</u> | | 13c. CITY OR TOWN <u>Foxcroft Hill</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>322 E. Jarrettville Rd</u> | | | | | | | |
| 14. FATHER'S NAME FIRST <u>Wiley</u> MIDDLE <u></u> LAST <u>Lyon</u> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Margaret</u> MIDDLE <u></u> LAST <u>Miles</u> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u>238-05-7042</u> | | 17. INFORMANT <u>Bina B. Lyon</u> | | | | ADDRESS <u>same as above</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140 Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> : (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquest <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Willard R Amoss</u> | | | | TITLE (SPECIFY) <u>Asst. Dir.</u> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <u>1/6/79</u> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Willard R Amoss</u> | | | | ADDRESS <u>2404 Pleasantville Rd, Fallston Md</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | 23b. DATE <u>1/10/1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u> | | | | 23d. LOCATION CITY OR TOWN <u>Bel Air</u> COUNTY <u>Harford</u> STATE <u>Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>M. G. Kurtz</u> ADDRESS <u>111 Jarrettville, Md.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 11 1979</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u> | | | | | | | |

MEDICAL CERTIFICATION

5810-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01843 REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Franklin Maines, Sr. | | | | 2a. DATE OF DEATH MONTH Jan DAY 3 YEAR 1979 | | | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH July DAY 1 YEAR 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Quarry | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Harford 13c. CITY OR TOWN Street | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box 247 Old Scarborough Rd. | |
| 14. FATHER'S NAME FIRST Sheridan MIDDLE LAST Maines | | | | 15. MOTHER'S MAIDEN NAME FIRST Susie MIDDLE LAST Widener | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-26-0001 | | 17. INFORMANT ADDRESS Mrs. Minnie Maines, Street, Md. 21154 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 410- DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis with coronary artery disease | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diagnosed depression, cerebrovascular insufficiency | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 , 19 78 , to Jan 3 , 19 79 , that (I) (we) lost saw the deceased alive on Jan. 3 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE | | 22c. DATE SIGNED 1/3/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. H. YAMAKAWA M.D. | | | | 22e. ADDRESS 319 So. Union Ave Havre de Grace Md. 21078 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/79 | | 23c. NAME OF CEMETERY OR CREMATORY Welcome Home | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Md. | |
| 24. FUNERAL DIRECTOR NAME John H. Harkins ADDRESS Delta, Pa. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

29-01843



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01844
REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| Lillian E. McDougal | | Jan. 21 1979 | | 3:10 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 76 YRS. | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Fallston, Md. | Fallston Gen Hospital | | Retired | | House Wife |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md | Harford | Port Deposit | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Box 100 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| William H. Gannon | | Mary Lillian Gardner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 217-50-3322 | | Beverly A. Narvel, Port Deposit, Maryland. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CEREBRAL DEATH | | | | | |
| 436- DUE TO, OR AS A CONSEQUENCE OF STROKE | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Dante W. Monakie | | M.D. | | 1/23/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DANTE W. MONAKIE, MD | | 622 S Union St. Harford, Md 21070 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Jan. 25, 1979 | West Nottingham Cem | Celora, Cecil, Maryland | |
| 24. FUNERAL DIRECTOR OR | | 25. DATE REC'D BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | |
| Lee H. Patterson & Son, Perryville, Md. | | JAN 29 1979 | | | |

MEDICAL CERTIFICATION

44810-02

X

NOTICE
MAY 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-01845

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY McGill McKnight | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 25 79 | | | 2b. HOUR 7³⁰ P.M. | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 09 26 96 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | | |
| 13a. STATE MD. | | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN FALLSTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Fork, Md. 21051 12801 Harford Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Anderson DeLong | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy McGill | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 089-07-5871 | | 17. INFORMANT ADDRESS 21051 Md. Nancy Barbara McKnight P.O. Box 5, Fork | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) multiple sclerosis | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Brian T. Yeo, M.D. | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/26/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yeo | | | 22e. ADDRESS 801 Union Ave. Havre de Grace, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/26/79 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westview Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME E.F. Lassahn Funeral Home | | | ADDRESS Kingsville, Md. 21094 | | DATE REC'D. BY REGISTRAR JAN 30 1979 | | 25b. REGISTRAR'S SIGNATURE L. H. B. B. B. | | | |

24810-05

24810-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-01846
REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Ervin Mitchell | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-26-79 | | | 2b. HOUR 2:20 A M | | | | |
| 3 SEX Male | | 4 RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR June 25, 1937 | | 6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Appliances | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Bel Air | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 205 Archer Street | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Ervin Lewis Mitchell | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Ida Taylor | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-32-9360 | | 17 INFORMANT ADDRESS Betty A. Mitchell same as above | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Bleeding, Massive 5728 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Portal Hypertension (c) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RENAL FAILURE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19-79 to 1-26-79, that (I) (we) last saw the deceased alive on 1-25-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Perfecto C Valerao | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1-26-79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PERFECTO C VALERAO | | | 22e. ADDRESS 1710 A HARFORD Rd, Fallston | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/30/1979 | | 23c. NAME OF CEMETERY OR CREMATORY St. James Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Jarrettsville, Harford, Md. | | |
| 24. FUNERAL DIRECTOR NAME M. G. Kurtz III | | | ADDRESS Jarrettsville, Md. | | | 25a. DATE REG'D. BY REGISTRAR JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

BP

84810-85

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-01847 REG. NO. | |
|--|---------------------|--|--|--|--|--|--|--|-------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Grace M. Norris | | | | | | 2a. DATE KNOWN OF DEATH 12/12/79 | | 7b. HOUR 5:40 AM | | | |
| 3. SEX F | 4. RACE Cauc | 5. DATE OF BIRTH 7/8/1903 | | 6. AGE (IN YEARS) 75 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 12/19/79 | | 7d. HOUR M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD. | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md | | 13b. CITY Hartford | | 13c. CITY OR TOWN Street | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3546 Prospect Road | | | |
| 14. FATHER'S NAME FIRST John MIDDLE LAST Morgan | | | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST Hughes | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-46-9704 | | 17. INFORMANT Edward Norris ADDRESS 3546 Prospect Rd. Street, Md. 21154 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Willard R. Amoss | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 1/12/79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Willard R. Amoss | | | | ADDRESS 2404 Pleasantville Rd, Fallston | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY Slate Ridge | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delta York Co. Pa. | | | |
| 24. FUNERAL DIRECTOR NAME John H. Harkins ADDRESS Delta, Pa. | | | | | | 25a. DATE REG'D. BY REGISTRAR JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

74810-05



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01848

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ursula I. Notter | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-07-79 | | 2b. HOUR 3 AM |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 10 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. | |
| 10. CITY OR TOWN OF DEATH Joppa, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 418 Foster Knoll Dr. Joppa, Md. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Teller | 12b. KIND OF BUSINESS OR INDUSTRY 1 st. National | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Harford | 13c. CITY OR TOWN Joppa | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Kurt Schwabe | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Rossburg | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 234-80-5551 | | 17. INFORMANT ADDRESS Joppa, Md. 21085 Mr. Paul E. Notter, 418 Foster Knoll Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos ± | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) obtained the deceased from <u>4/79</u> , 19 <u>1-7-79</u> , to <u>1-7-79</u> , that (I) (we) lost saw the deceased alive on <u>12/30/78</u> , 19 <u>1978</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Bernard J. Yukna MD</u> | | | 22c. DATE SIGNED 1-8-79 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD J. YUKNA, MD.A.B.F.P. | | | 22f. ADDRESS 404 BOWLEYS QUARTERS ROAD/BALTO/21220 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-1979 | | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Huntington, Cabell Co. W. Va. | | 23e. DATE REC'D. BY REGISTRAR JAN 11 1979 | | | |
| 24. FUNERAL DIRECTOR NAME E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 | | 25a. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VR A 15 (4)) 9/74

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1-8-79

BERNARD J. YOUNG, M.D., B.F. 404 BOWLEY'S QUARTERS ROAD, BALTON, 21020

1-2-1

1-2-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01849 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Loretta S. Parks | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 16 '79 | | 2b. HOUR 6:30 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 7 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. | |
| 10. CITY OR TOWN OF DEATH Abingdon | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3907 East Baker Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Abingdon | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Winfield B. Morgan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta Cummings | | 13e. STREET ADDRESS 3907 East Baker Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-03-7946 | | 17. INFORMANT ADDRESS Philip S. Parks, 3907 East Baker Ave. 21009 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Primary carcinoma of lung.</i> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic heart failure decompensated.</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/16/78</i> to <i>1-16-79</i> , that (I) (we) last saw the deceased alive on <i>1-16-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/17/79.</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MEZEI</i> | | 22e. ADDRESS <i>HAYRE DE GAGE, MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/19/79 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc., 6500 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

BP

13-01819

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01850 REG. NO. | | | | |
|---|---|--|--|--|--|---|--|---------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) ODIE S PERKINS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-7-79 | | | | 2b. HOUR 12:55 P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept 9 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | |
| 10. CITY OR TOWN OF DEATH HARFORD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE MD 13b. COUNTY Cecil 13c. CITY OR TOWN NORTH EAST | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1 Rt 272 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Sams | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST No INFO | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 233-30-5042 | | 17. INFORMANT ADDRESS Sarah E. Creswell Port Deposit, Md. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line or (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease + Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) failure (c) failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-7-79 to 1-7-79 , that (I) (we) last saw the deceased alive on 1-7-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE John D. Yun DEGREE | | | | 22c. DATE SIGNED 1/7/79 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun | | | | 23b. ADDRESS Home degree, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-79 | | 23c. NAME OF CEMETERY OR CREMATORY Bayview | | 23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md. | | |
| 24. FUNERAL DIRECTOR NAME Paul R. Brouck ADDRESS North East, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy | | |

BP

02810-97

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01851 REG. NO. | | |
|--|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETTA MAE PETTRY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 23 79 | | | 2b. HOUR 7⁵⁵ P.M. | | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2 8 1889 | | 6 AGE (IN YEARS LAST BIRTHDAY) 89 | | IF UNDER 1 YEAR MONTHS DAYS 11 27 | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD CITY MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH BEL AIR | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BELAIR CONValesCENT CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD. | | | | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN HAVRE DE GRACE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 101 BROTHERTON CT | |
| 14 FATHER'S NAME FIRST MIDDLE LAST THOMAS ALLEN | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY XXXXXXXX Etta Roach | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 235-54-1645 | | 17 INFORMANT ADDRESS Grace, Md. 21078 Frank Petry, 101 Brotherton Ct., Havre de | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 486- DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bron Syndrome due to smoke from chimney | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hr. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4-16-79 P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-23-79 | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 4-16-79 to 1-23-79 , and that (b) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (a) did not view the body after death, so say.) | | | | | | | | | | | | |
| 22b. SIGNATURE Peter P. Redman, M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-25-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 8 Lan St Aberdeen, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 26 Jan. 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, R.D., Harford Md. | | | | |
| 24 FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., | | | | ADDRESS Aberdeen, Md. 21001 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |

BP

12810-21

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01852 REG. NO. | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Leola F. Pierce</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 18, 1979</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>MAY 28, 1905</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>73 YRS.</i> YRS. MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH <i>Havre de Grace</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hospital</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i> | | | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Harford</i> | | 13c. CITY OR TOWN <i>Havre de Grace</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN William Fulton</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELLEN ELLEN Barrow</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | 16b. SOCIAL SECURITY NO. <i>216-52-8955</i> | | 17. INFORMANT ADDRESS <i>MR. GEORGE A. PIERCE - SAME</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410- (1) Central Vascular (Hemorrhage)</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart disease</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 dg</i> <i>2 dg</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-11</i> , 19 <i>79</i> , to <i>1-18</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>1-18</i> , 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>IRVIN L. WACHSMAN</i> | | DEGREE | | 22c. DATE SIGNED <i>1/18/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>IRVIN L. WACHSMAN</i> | | 22e. ADDRESS <i>407 S. UNION AVE. HAVRE DE GRACE MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>JAN 20, 79</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEM. HAVRE DE GRACE, HARFORD MD</i> | |
| 24. FUNERAL DIRECTOR NAME <i>R. Madison Mitchell</i> | | ADDRESS <i>HAVRE DE GRACE, MD.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 22 1979</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i> | |

22010-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 79-01853 REG. NO. | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST CAROL TAYLOR Redden | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 4 79 | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 4, 1890 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 88 YRS. | |
| 10. CITY OR TOWN OF DEATH HARFORD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 13a. STATE Md | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN CONOWINGO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William TAYLOR Redden | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE TILGHMAN | | 17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown | | 16b. SOCIAL SECURITY NO. 716-01-6814 | | 17. INFORMANT ADDRESS Clifford E. Redden, Conowingo, Maryland. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>1889</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of bladder.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-31</u> , 19 <u>78</u> , to <u>1-4</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Louis E. Renjel MD | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS E. RENJEL MD | | | | 22e. ADDRESS 464 Alliance St. Harford, Md. 21078 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 8, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery, Calmar, Cecil Maryland | |
| 24. FUNERAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland. | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JAN 11 1979 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

28-01823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01854 REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LORETTA M. REIDER | | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 1 79 | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12 31 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH HARFORD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY School | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Abingdon | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ANSON WEEDEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN BRENEGAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 522-38-4960 | | 17. INFORMANT ADDRESS Martin F. Reider, Jr., Abingdon, Md. 21009 3707 Philadelphia Blvd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 4349 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-24, 1978, to 1-1, 1979, that (I) (we) last saw the deceased alive on 1-1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John D. Yun | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN | | | | 22e. ADDRESS Hume de Grace, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4 Jan. 1979 | | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, R.D., Harford Maryland | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

42810-02

10 01 1933

221-2-222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01855 REG. NO. | |
|---|--|---|--|---|--|---|--|--|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH NMN RINALDI | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-29-79 | | | 2b. HOUR 8:30 A M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 9, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | | |
| 10. CITY OR TOWN OF DEATH HAVER DE GRACE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY Wiley Mfg. Co. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY CECIL 13c. CITY OR TOWN PORT DEPOSIT | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RD 1 JACKSON PARK RD. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Rinaldi | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rinaldi | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-10-6199 | | 17. INFORMANT ADDRESS Antonette Rinaldi, Port Deposit, Maryland. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic lung disease DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD & TB Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19 , 19 79 , to 1-29 , 19 79 , that (I) (we) lost saw the deceased alive on 1-29 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Luis E. Renjel DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS E. RENJEL | | | | 22e. ADDRESS 464 Alliance St. Haver de Grace | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 31, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun, Cecil, Maryland. | | | | | |
| 24. FUNERAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland. | | | | 25. DATE REC'D. BY REGISTRAR FEB 1 1979 | | 26. REGISTRAR'S SIGNATURE Jeffrey McBratney | | | | | |

52810-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-01856

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|---|---|------------------------------|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Margaret LAST Smith | | | 2a. DATE OF DEATH MONTH DAY YEAR January 13, 1979 | | | 2b. HOUR 3:32 P.M. | | | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bel Air | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 Vermont Place | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Harford Co. | | 13c. CITY OR TOWN Bel Air | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3 Vermont Place | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Klein | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Eckmeyer | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 214-74-8036 | |
| 17. INFORMANT (NAME) Son | | | 17. INFORMANT (ADDRESS) 1-914-963-8502 12 De Haven Dr. - Apt 1-D Yonkers, N.Y. 10703 | | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Ovary with Metastases 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) I did not view the body after death. | | | |
| 22b. SIGNATURE Dudley Phillips, M.D. | | 22c. DATE SIGNED Jan. 13, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips, M.D. | | 22e. ADDRESS Baltimore, Maryland 21034 | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 16, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014 | |
| 24. FUNERAL DIRECTOR Joseph William Foster Bel Air, Maryland 21014 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-01857 REG. NO. | |
|---|------------------|---|---|---|------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST E. Paul Snodgrass | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 17 19 79 | | 2b. HOUR 248 M | | | |
| 3. SEX M | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 23/1899 | 6. AGE (IN YEARS) LAST BIRTHDAY 79 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 M | | 2d. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Dealer | | 12b. KIND OF BUSINESS OR INDUSTRY Auto | | | |
| 13a. STATE Md | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Street | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3908 Street Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Harry Snodgrass | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alvaria Steltz | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 246-32-4452 | | 17. INFORMANT Mrs. Margaret Snodgrass, Street Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Cardiac Arrest (b) Acute Myocardial Infarction (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 2d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Willard R. Amoss | | | | TITLE (SPECIFY) Asst Deputy | | | | DATE SIGNED 1/7/79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Willard R. Amoss | | | | ADDRESS 2404 Pleasantville Rd Fallston Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/10/79 | | 23c. NAME OF CEMETERY OR CREMATORY Highland Church Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Street, Harford, Md. | |
| 24. FUNERAL DIRECTOR NAME John H. Harkins | | | | ADDRESS Delta, Pa. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE Jeffrey McBrady | |

MEDICAL CERTIFICATION

72810-07

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01858

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|---|----------------------|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM JAMES SNYDER JR | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-7-79 | | 2b. HOUR 10:37 ^A _M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 29 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | 10. CITY OR TOWN OF DEATH LAUREL DE GRACE | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Asst. | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. | | 13b. COUNTY CECIL | | 13c. CITY OR TOWN RISING SUN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William James Snyder Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Coulter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 187-18-7342 | | 17. INFORMANT ADDRESS Bessie Snyder same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-15 , 19 78 , to 1-7 , 19 79 , that (I) (we) last saw the deceased alive on 1-7 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Neil Taylor MD | | DEGREE MD | | 22c. DATE SIGNED 1-7-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor Jr MD | | 22e. ADDRESS Rising Sun, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-79 | | 23c. NAME OF CEMETERY OR CREMATORY West Nottingham | |
| 23d. LOCATION CITY OR TOWN Cecil COUNTY Maryland STATE | | 25a. DATED AND BY REGISTRAR 1-10-79 | | | |
| 24. FUNERAL DIRECTOR NAME W. E. Mullen ADDRESS Rising Sun, Md. | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

CONFIDENTIAL

1. The first part of the document discusses the importance of maintaining accurate records of all activities. It emphasizes that this is crucial for ensuring transparency and accountability in the organization's operations.

2. The second part of the document outlines the specific procedures for collecting and analyzing data. It details the steps involved in identifying key performance indicators (KPIs) and the methods used to gather relevant information.

3. The third part of the document describes the results of the data analysis. It highlights the trends observed over the specified period and discusses the implications of these findings for the organization's strategic goals.

4. The fourth part of the document provides a summary of the findings and offers recommendations for future actions. It suggests areas where the organization can improve its performance and provides a timeline for implementing these changes.

5. The fifth part of the document is a conclusion that reiterates the importance of the data analysis process and expresses confidence in the organization's ability to achieve its long-term objectives.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH **79-01859**

| | | | | | |
|---|---|---|----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| OLIVER LeRoy SPICER | | 1-1-1979 | | 11:23 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| M | Cauc | Apr. 25, 1900 | 78 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | WIDOWED | DIVORCED |
| Maryland | USA | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Fallston | FALLSTON GENERAL Hospital | Maintenance Man | | US-govt. Ret | |
| 13a. STATE | 13b. COUNTY | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | | |
| Md. | Harford | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 215 Chmerville Rd. | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| George Brown Spicer | Louisa -- Turner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| no | 220-22-0090 | Mrs. Alice M. Spicer, Bel Air, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 4140 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular Arteriosclerotic Disease | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED |
| Willard P. Amoss | M.D. Deputy | | | | 1/2/79 |
| EXAMINER'S NAME (TYPE OR PRINT) | ADDRESS | | | | |
| Willard P. Amoss | 2404 Pleasantville Rd. | | Fallston, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | Jan. 4, 1979 | Bel Air Mem. Gardens | Bel Air | Harford | Md. |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Howard K. McComas III, Abingdon, Md. | | JAN 4 1979 | | Rickey McCready | |

12-01822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73
(VRA 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01860 REG. NO. | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES M. STAUFFER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 2, 1979 | | 2b. HOUR 6:00 P | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 31, 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) York, Penna. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Cardiff | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dooley Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE Maryland | | 13b COUNTY Harford | | 13c CITY OR TOWN Cardiff | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS Dooley Road | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 214-18-1670 | | 17 INFORMANT ADDRESS Eleanor S. Scotten, Cardiff, Md. 21024 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Dec 31, 1978 to Jan 2, 1979 , that (I) (we) lost saw the deceased alive on Dec 31, 1978 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Josiah A Hunt M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Jan. 3, 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Josiah A. Hunt | | | | 22e. ADDRESS Delta, Pennsylvania 17314 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 5, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Slate Ridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delta York Penna. | | | | | |
| 24. FUNERAL DIRECTOR NAME John H. Harkins, Delta, Penna. | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy | | | |

BP

53-01880

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01861

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|-------------------|--|--|--|------------------|--|---|--|-------|--|---|--|------|--|----------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emory | | Stewart | | | | | | 1 | | 5 | | 19 | | 79 | | 4:30 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M | | B | | 9 1 18 | | 60 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN | | 19 | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Harford MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fallston | | | | Fallston General Hospital | | | | | | | | Chauffer | | | | Government | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | | | | | | 13b. COUNTY | | | | | | | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MD | | | | | | | | | | | | | | | | Harford | | | | | | | | | | | | | | | | Edgewood, Md | | | | | | | | | | | | | | | | YES | | | | | | | | | | | | | | | | 2134 Battle St | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | | | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Howard Edward Stewart | | | | | | | | | | | | | | | | Ada Mary Kell | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | 1945 | | | | | | | | | | | | | | | | 218-18-3553 | | | | | | | | | | | | | | | | Dorothy Stewart | | | | | | | | | | | | | | | | same as above | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | Respiratory Distress and Failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | Chronic Obstructive Pulmonary Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| W. Amos | | | | | | | | | | | | | | | | Dorothy | | | | | | | | | | | | | | | | 1/5/79 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Willard P. Amos | | | | | | | | | | | | | | | | 2404 Pleasantville Rd, Fallston, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | | | | | | 23b. DATE | | | | | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | | | | | | | 1/10/1979 | | | | | | | | | | | | | | | | Fairview | | | | | | | | | | | | | | | | Forest Hill, Harford, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. G. Kurtz III | | | | | | | | | | | | | | | | Jarrettsville, Md. | | | | | | | | | | | | | | | | 21084 JAN 11 1979 | | | | | | | | | | | | | | | | Dorothy McCreedy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

12810-25

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01862

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|------------------|---|-------------------|---------------------|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 20. DATE KNOWN OF DEATH | | | 21. DATE OF DEATH | | | 22. DATE OF DEATH | | | 23. DATE OF DEATH | | | 24. DATE OF DEATH | | |
| George Hugh Swartz, Sr. | | | 1-11 1979 | | | 1-11 1979 | | | 1-11 1979 | | | 1-11 1979 | | | 1-11 1979 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| M | W | 1 28 16 | 62 YRS. | | | HARFORD | | | HARFORD | | | HARFORD Memorial Hosp | | | Retired | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | 13f. STREET ADDRESS | | |
| Md | | | HARFORD | | | Aberdeen | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 753 MAHAN | | | Aberdeen | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. CAUSE OF DEATH | | |
| Oren | | | NINA XXXXXXX Baker | | | Yes | | | 058-18-1585 | | | Chart Hospital | | | CORONARY heart disease | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. MONTH DAY YEAR | | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | |
| | | | | | | | | | | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | 22a. I certify that I took charge of the remains described above, held on | | | 22b. TIME OF INJURY | | | 22c. HOW INJURY OCCURRED | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | STREET, FACTORY, FARM, ETC.) | | | STREET | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | HOUR A.M. MONTH DAY YEAR | | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | 23e. DATE REC'D. BY REGISTRAR | | | 23f. REGISTRAR'S SIGNATURE | | |
| Burial | | | Jan. 15, 1979 | | | Harford Mem. Gardens | | | Aldino | | | JAN 17 1979 | | | Harford Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | 25c. DATE REC'D. BY REGISTRAR | | | 25d. REGISTRAR'S SIGNATURE | | | 25e. DATE REC'D. BY REGISTRAR | | |
| Howard K. McComas III, Abingdon, Md. | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

10-01805

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-01863 | |
|---|--|--|--|---|--|---|--|---|---------------------------|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Edward J. Wainwright | | | | | | 2a. DATE OF DEATH MONTH Jan. DAY 3rd YEAR 79 | | | 2b. HOUR 2 p.m. | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 5 DAY 27 YEAR 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Pittsford, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 2125 Battle St. Md. | | | |
| 13a. STATE Md. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Edgewood | | | | | | | |
| 14. FATHER'S NAME FIRST Oscar MIDDLE Wainwright LAST | | 15. MOTHER'S MAIDEN NAME FIRST Carrie MIDDLE Robinson LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 219-03-673 | | 17. INFORMANT Albert Wainwright | | ADDRESS Ph 2 Anne Bolton Box 427 Hill | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardioresp. arrest 1629 DUE TO, OR AS A CONSEQUENCE OF: (b) metastatic CA to brain 2-3 mo. (c) lung CA several mo. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 15, 1978 to Jan 3rd 1979 , that (1) (we) lost saw the deceased alive on Jan 2nd 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE Albert S. C. Sun | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Jan 3rd 79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun | | 22e. ADDRESS Fallston Hosp. 21047 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 1-12-79 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME John ADDRESS Fallston Md | | 25a. DATE REC'D. BY REGISTRAR JAN 11 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

BP

20810-02

20810-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 79-01864 REG. NO. | |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JETTIE E. WALLER | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 9, 1979 | | 2b. HOUR 3³⁰ A M |
| 3. SEX Female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 12 7 1915 | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH HAURE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md. | 13b. COUNTY HARFORD | 13c. CITY OR TOWN Aberdeen | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 709 BEARDS HILL Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alonzo Scott | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Gore | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 223-20-2842 | | 17. INFORMANT ADDRESS Raymond F. Waller, 709 Beards Hill Rd., Aberdeen Maryland 21001 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Advanced vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION DEC 27, 1978 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene right leg | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 25 , 19 78 , to Jan 9 , 19 79 , that (I) (we) lost saw the deceased alive on Jan 9 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | 22c. DATE SIGNED Jan 9, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAW J. SOMERVILLE | | 22e. ADDRESS 400 LEWIS ST HARRE DE GRACE Md 21078 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11 Jan. 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JAN 11 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

19-01884

19-01884

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01865
REG. NO.

| | | | | | | | | | | | |
|---|---------------|---|---|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 13 19 79 5 14 M | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles H. Weber Jr. | | 2b. DATE OF DEATH MONTH DAY YEAR 1 13 19 79 5 14 M | | | | | | | | | |
| 3. SEX M | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 6 9 37 | 6. AGE (IN YEARS) LAST BIRTHDAY 41 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 1 13 19 79 5 14 M | | 9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC | | | 12b. KIND OF BUSINESS OR INDUSTRY AUTO | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC | | | 12b. KIND OF BUSINESS OR INDUSTRY AUTO | | |
| 13a. STATE Md | | 13b. COUNTY Hartford | 13c. CITY OR TOWN White Hall | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 5322 Norrisville Rd 21161 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. WEBER, SR | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH COPEN HAVER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-32-7064 | | 17. INFORMANT P. S. WEBER | | ADDRESS WHITE HALL, MD. 21161 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Auto Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Willard P. Amoss | | TITLE (SPECIFY) M.D. Deputy | | MEDICAL EXAMINER | | DATE SIGNED 1/14/79 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss | | ADDRESS 2404 Pleasantville Rd, Fallston Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/16/79 | | 23c. NAME OF CEMETERY OR CREMATORY NORRISVILLE CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE NORRISVILLE HARTFORD MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME Kenneth W. Orban | | ADDRESS Stewart St | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1979 | | 25b. REGISTRAR'S SIGNATURE History McCreedy | | | | | |

20810-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-01866

| | | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|---|--|-----------------------------------|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert Lee Whitt | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-12-1979 | | | 2b. HOUR 12:58 P.M. | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Fellston | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fellston General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver Hauling | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Edgewood | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 2230 Rosewood Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter H. Whitt | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leola -- Lawson | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. Korean 213-30-9027 | | | 17. INFORMANT ADDRESS Mrs. Mary E. Whitt, Edgewood, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPUL. ARREST</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC CA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Howell</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H McWilliams</i> | | | | | | 22e. ADDRESS <i>Fellston</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 15, 1979 | | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>John H. Brady</i> | | | | | |

78-01866

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1-AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A13 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01867
REG. NO.

1- FOR
STATE
REGISTRAR

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|---|---------|--|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTI- MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Mande | | E. | | Wood | | | | 1/26 | | 19 | | 79 | | 42 | | PM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| F | CAUC | 4/15/07 | | 71 | | YRS. | | | | 1/26 | | 19 | | 79 | | 515 | | PM | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| N. CAROLINA | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| FALLSTON | | FALLSTON GENERAL HOSPITAL | | HOUSEWIFE | | OWN HOME | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| MA | | Baltimore | | STREET | | YES | | BOX 4-32 POOLE RD | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| WILEY | | MARGARET | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 316-66-7670 | | MR. ROBEY WOOD | | SAME AS # 13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| 4/140 | | Cardiac Arrest | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | Arteriosclerotic heart disease | | | | | | | | | | | | | | | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-01868 | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CLYDE CLYDE | | L. MIDDLE L | | ZIMMERMAN ZIMMERMAN | | 2a. DATE OF DEATH MONTH DAY YEAR 1-13-1979 | | | | 2b. HOUR 7:30 A.M. | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 8-14-1941 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLANT MGR. | | 12b. KIND OF BUSINESS OR INDUSTRY Leonard Jed Co | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Jarrettsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3903 Boxwood Rd. Jarrettsville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Melvin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vivian Connley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-36-1272 | | 17. INFORMANT ADDRESS Mrs. Elizabeth A. Zimmerman 3903 Boxwood Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopul. arrest</u> 1950 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cr., weak</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>William W. ...</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-16-1979 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Rd. Bal to; Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE <i>John H. ...</i> | | | |

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